

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS2725AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/04/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>AGAPE LOVE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1211 NORTH H STREET LAS VEGAS, NV 89106</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 1/4/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A.</p> <p>The facility is licensed for four Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category I residents. The census at the time of the survey was three. No resident files were reviewed and three employee files were reviewed.</p> <p>The following deficiencies were identified:</p>	Y 000			
Y 106 SS=D	<p>449.200(2)(a) Personnel File - 1st aid &amp; CPR</p> <p>NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.</p> <p>This Regulation is not met as evidenced by:</p>	Y 106			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 106	Continued From page 1  Based on record review on 1/4/11, the facility failed to ensure that 1 of 3 caregivers were trained in first aid and cardiopulmonary resuscitation (Employee #3-CPR card had expired on 9/20/10).  Severity: 2 Scope: 1	Y 106			
Y 253 SS=F	449.217(4) Adequate Supplies of Food  NAC 449.217 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times.  This Regulation is not met as evidenced by: Based on observation and interview on 1/4/11, the facility failed to provide at least a 2-day supply of fresh food in the facility for 3 of 3 residents.  This was a repeat deficiency from the 8/24/10 annual State Licensure survey.  Severity: 2          Scope: 3	Y 253			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.